**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
David Taylor, MD

**Respondent Name**
Indemnity Insurance Company of North America

**MFDR Tracking Number**
M4-14-3633-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
August 12, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The patient…was examined by Dr. David Taylor on 03/27/14, and the claim was faxed to the insurance carrier, the TDI-DWC, and mailed to the patient on 04/03/14. The insurance carrier was billed $650 for services, yet, on June 19, 2014, payment was received in the amount of $500. On June 27, 2014, a follow up letter was mailed to the insurance carrier requesting the additional $150. It was explained in the request that the 9945-W5-WP is coding for an MMI and ROM, which was performed on the patient, and $650 is the appropriate charge in accordance with rule 134.204.

A second EOB, dated July 31, 2014, was received from the insurance carrier. The carrier did not pay the additional amount but denied the request. Message on the EOB:

> Exact duplicate claim/service, duplicate charge, the time for limit for filing was expired.

I am submitting the required documents – original claim, MD notes, and EOBs."

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Broadspire on behalf of Indemnity Insurance Co of North America asserts that the examination with Dr. Taylor was not a designated doctor examination. The claimant was referred to Dr. Taylor by his treating doctor and the exam was not set by TDI-DWC. Dr. Taylor bill for DDE with 99456-WP. The modifier W5 was not billed. It is our position because this was not a designated doctor exam, no additional fees are due."

**Response Submitted by:** Broadspire, 8827 W. Sam Houston Parkway N, Suite 110, Houston, TX 77040

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 27, 2014 | Examination to Determine Maximum Medical Improvement and Impairment Rating by a Doctor other than the Treating Doctor | $150.00 | $150.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Administrative Code §134.204 (j) sets out the procedure for billing and reimbursing examinations for Maximum Medical Improvement and Impairment Rating.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - W1 – Workers' Compensation jurisdictional fee schedule adjustment
   - W1 – Case management treating doc
   - 18 – Exact duplicate claim/service
   - 224 – Duplicate charge.
   - D10 – The time limit for filing has expired

**Issues**

1. Did the requestor bill correctly for the examination to determine Maximum Medical Improvement and Impairment Rating?
2. What is the correct MAR for this examination to determine Maximum Medical Improvement and Impairment Rating by a doctor other than the Treating Doctor?

**Findings**

1. Per 28 Texas Administrative Code §134.204 (j)(3)(C), "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   Per 28 Texas Administrative Code §134.204 (j)(4)C)(iii), "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR."

   Review of the submitted documentation finds that the original bill was submitted using CPT Code 99456 with modifier WP. Therefore, the requestor did bill correctly for the examination to determine Maximum Medical Improvement and Impairment Rating.
2. As noted above in 28 Texas Administrative Code §134.204 (j)(3)(C), the correct MAR for an examination to determine Maximum Medical Improvement is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4)(C), "The MAR for musculoskeletal body areas shall be as follows…(II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The narrative report indicates that a full physical examination with range of motion was performed. Therefore, the correct MAR for examination to determine Impairment Rating is $300.00.

   The total MAR is found to be $650.00. The requestor billed $650.00. On June 19, 2014, the insurance carrier reimbursed $500.00. The Division finds that $150.00 remains reimbursable.

   While all evidence may not have been discussed, it was reviewed and considered.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Laurie Garnes<br>Medical Fee Dispute Resolution Officer | December 18, 2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.